Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

April 18, 2017

Ms. Deborah McCormick, Manager
Scenic View Rural Edge LLC
979 Vt Route 100
Westfield, VT 05874-0154

Dear Ms. McCormick:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on March 13, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0151	A. BUILDING: _____ B. WING _____	C 03/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC VIEW RURAL EDGE LLC	979 VT ROUTE 100 WESTFIELD, VT 05874

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R100	Initial Comments: An unannounced onsite investigation of two complaints was completed by the Division of Licensing and Protection on 3/13/17. Based on information gathered, regulatory violations were identified as follows:	R100		
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide the necessary care to address the residents' medical needs regarding medication management for 1 of 6 residents in the total sample. (Resident #6) Findings include: Per staff interview and record review, Resident #6's time for administration of Lantus insulin, a long acting insulin, was changed by staff and administered to the resident prior to obtaining a physician order. A note documented in the staff communication book regarding Resident #6 stated " [Resident #6] has been receiving -- Lantus (insulin) at 4:30 - MD ordered it @ 8 PM....we have to do an order to change it.". Per interview with the RN on duty, s/he was not able to locate a signed physician order for Lantus with a time specified, during the on-site time.	R126 DATE: May 1. 2017	Action: 1. Confirm administration time of medication per physician order 2. Ensure type of insulin is identified on MAR, as well as correct insulin signed off when administered 3. Ensure all staff members have been properly trained and have corresponding documentation	May 1. 2017

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Adm. 4/13/2017

R126 - R999 POCs accepted 4/18/17 JHarmon RN/PMC

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R126	Continued From page 1 The actions of the facility staff posed a significant safety risk to the resident (changing the time of administration of a long acting type of insulin). Per reference, Nursing Drug Handbook, "Lantus has an onset of 1 hour, no peak and duration of 24 hours". On 3/15/17, the Administrator presented electronic evidence that showed that staff document administration of medication via a signature sheet that includes a list of all residents of the home, and a chart with days of each month. Staff then initial under the appropriate date and time slot, for example 4 PM, that indicates that all medication due at 4 o'clock was administered. Per review of the form, under the heading 4 PM, for Resident #6, the record stated under the time of 4:30 PM, only the word "insulin". It did not state the name of the insulin ordered by the provider, nor that 2 different types of insulin were administered at that time. Per review of the documentation provided, the other insulin ordered was Humalog (lispro) which is a rapid acting insulin given in accordance with a sliding scale, dependent upon the results of BS (blood sugar) tests conducted before each meal. (Reference manual states, "inject (Humalog) subcutaneously within 15 minutes before or after a meal". Policies and procedures requested and training records to show evidence of specific training for administration of insulin by unlicensed staff were not found, per the Registered Nurse on duty on 3/13/17. Refer also to R 168.	R126	Meaning: 1. Ensure only RN is making changes to MAR and those changes are based on signed physician orders. 2. Type of insulin and time administered correspond w/ signed physician order 3. All staff administering medication will have skills checklist completed and documentation in personnel file Actions: 1. RN only employee allowed to make changes to MAR, and will sign/date all changes 2. All new orders will be reviewed for accuracy by RN; all other orders reviewed for accuracy monthly 3. RN administer test and skills checklist to all staff administering medications	

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R145	Continued From page 2	R145		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a written plan of care for 2 of 6 residents in the sample (#2 and #4) which describes the care and services necessary to address all identified needs and maintain well-being. Findings include: 1. During record review and staff interview, Resident #2 was found to have a history of risk of sexual behavior toward others. The written care plan did not identify this risk so that staff might appropriately monitor for such behavior. 2. During record review and staff interview, Resident #4 was found to have allegedly made a sexual gesture toward Resident #3 on 2/27/17. The written plan of care for Resident #4 did not reflect the need for awareness of staff regarding monitoring for risk of such behavior. During interview at 4:30 PM on 3/13/17, the Administrator confirmed that neither Resident #2 nor #4 had a care plan regarding potential sexual behaviors.	R145	Action: Careplans for #2 & #4 will be updated to reflect a plan for regarding potential sexual behaviors Measures: Care plans will identify a course of action for any sexual behaviors and appropriate follow up measures Monitored RN & all other staff members will monitor for sexual behaviors as outlined in care plans and implement course of action as described in care plan	April 12, 2017

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R160 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission. (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home. (3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration. (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	R160	Action: 1. All outdated and censured medications will disposed of by RN per facility P&P Measure 1. updated P&P updated to include periodic check for outdated medication for residents no longer in facility. Monitored 1. RN & Office Mgr review and destroy any expired meds on a monthly basis Action 2. All residents currently receiving psychoactive medications will have AIMS testing done every 6m. measure: 2. P&P established to ensure every 6m AIMS testing is complete	May 31, 2017 May 14, 2017

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R160	Continued From page 4 interview, the facility failed to provide evidence of a written policy/procedure to address the disposal of outdated or unused medication, and for monitoring side effects of psychoactive medications for 2 of 6 applicable residents. (Residents #1 and #4). Findings include: 1. During observation of the nurses' station on 3/13/17, the surveyor identified bubble pack cards of medication stacked on a shelf in a closet. After comparing the names with the current resident roster and the Medication Administration Record (MAR), it was determined that medications for residents who no longer reside at the facility remained stored in this closet. Additionally, there were discontinued medications for current residents. The facility failed to provide a written policy and procedure for disposing of outdated or unused medication, including designation of a person or persons with responsibility for the disposal. 2. During record review and staff interview on 3/13/17, the facility failed to provide evidence of written procedures for monitoring side effects of psychoactive medications. Two of 4 applicable residents in the sample (Residents #1 and #4) lacked evidence of a periodic screening for involuntary movements (tardive dyskinesia) known to be associated with antipsychotic medications administered to them. During interview at 4:30 PM on 3/13/17, the Administrator confirmed that no Policy and Procedure for disposal of discontinued or outdated medications was available. Additionally, neither the Registered Nurse on duty, nor the Administrator, was able to identify a current process for conducting or obtaining periodic side effect screenings for antipsychotic medications.	R160	Monitored: 2. Create an excel worksheet that identifies all "due date" for each resident that are to be completed monthly	

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R161 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the manager of the home failed to assure that all resident medications were handled according to written policies and procedures and that all staff were properly trained in the medication policies and procedures. This finding has the potential to affect all residents of the home receiving medication administration. Findings include: 1. During observation of medication administration on 3/13/17 at 11:50 AM, the unlicensed staff person performed a finger stick blood glucose test using a True Metrix glucometer device. After performing the test, the staff person used an alcohol swab to clean the glucometer which is used for multiple residents who have diabetes. During interviews after this observation, neither the Registered Nurse (RN) nor the Administrator (ADM) provided evidence that staff had received training in infection control procedures prior to performing direct resident care, and could not locate manufacturer recommendations for cleaning the glucometer. Upon research, it was found that the manufacturer (NIPRO Diagnostics of Ft Lauderdale, FL; www.Trividiahealth.com, page 46-54) recommends that the glucometer be	R161	Action: 1. Manufacturer recommendations for glucometer will be followed moving forward Measure: 1. Staff will be properly trained for moving manufacturer recommendations Monitored: 1. Direct observation by RN during cleaning of glucometer For # 2 & # 3 All previous POC	May 1. 2017

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R161	Continued From page 6 cleaned after use for 2 minutes using a Super Sani-cloth wipe, then air dried. At 4:45 PM the Administrator confirmed that the glucometer should be cleaned with other than alcohol and did not provide evidence of infection control training for unlicensed staff. 2. Per morning interview with the ADM and the current RN on 3/13/17, and per review of a list of unlicensed staff who administer medications to residents, the list lacked evidence of training provided to delegated unlicensed staff by the RN (e. g., date and RN signature). There were no written training materials for review, no evidence of competency testing, nor documentation of the RN's observation of medication administration during the training period of unlicensed staff. During further interview at 4:45 PM, the ADM confirmed the lack of written policies and procedures related to medication delegation, and the lack of evidence of the training and delegation by the RN. 3. Per observation of a supply closet off the nursing office, there were multiple over the counter medications, biologics and topical creams/ointments that were past the expiration dates. There were also bottles of partially used mouth wash containers, which were not labeled for any specific resident's use. There was no policy/procedure for checking for outdated medications or topical creams used for residents.	R161		
R166 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication	R166	Action: 1. P&P developed for preparing of medication by RN	May 5 2017

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R166	Continued From page 7 administration, unlicensed staff may administer medications under the following conditions: (4) All medications must be administered by the person who prepared the doses unless the nurse responsible for delegation approves of an alternative method of preparation and administration of the medications. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure that there was a policy/procedure to allow unlicensed staff to administer medications that they did not pour. This failure has the potential to adversely affect all residents of the home. Findings include: Per interview with the Registered Nurse (RN) on duty on 3/13/17, s/he described the process for the pre-pouring of medications by the RN, and the administration of the medication by the unlicensed caregivers. The policy/procedure (P/P) for pre-pouring of medications was requested for review and was not available for review. During a telephone interview with the Administrator (ADM) on 3/15/17 at 2:45 PM, the ADM confirmed that there was no specific P/P to address the use of a pre-pour system of medication administration. Documents presented for review, showing the process used at the facility, indicated an inadequate accounting of administration of each resident's medications over the course of each calendar day. Per review during survey, the trays used to store the resident medications are labeled only with times of the day, and no list of the medications grouped to be administered at that specific time of the day. The system as used fails to show that each resident's medication was administered in accordance with	R166	Measures: 1. P&P will address how medications are accounted for and administered @ proper time 2. Ensure medications are properly labeled for each administration time Monitoring 1. When medications are rec'd medication, time + dosage will be verified against the MAR and any mistakes corrected.	

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R166	Continued From page 8 physician orders.	R166		
R168 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (6) Insulin. Staff other than a nurse may administer insulin injections only when: i. The diabetic resident's condition and medication regimen is considered stable by the registered nurse who is responsible for delegating the administration; and ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; and iii. The registered nurse monitors the resident's condition regularly and is available when changes in condition or medication might occur. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide evidence of the additional training required by the RN (Registered Nurse) in order for unlicensed staff to administer insulin to designated diabetic residents of the home. Additionally, unlicensed staff changed the time of medication administration for a type of insulin	R168	Reference POC from R126	

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R168	Continued From page 9	R168		

without obtaining a physician order for 1 of 6 residents sampled (Resident #6). Findings include:

Per staff interview and record review, Resident #6's time for administration of Lantus insulin, a long acting insulin, was changed by staff and administered to the resident prior to obtaining a physician order for the time change. A note documented in the staff communication book regarding Resident #6 stated "[resident name] has been receiving -- Lantus (insulin) at 4:30 PM - MD ordered it @ 8 PM....we have to do an order to change it.". Per interview with the RN on duty, s/he was not able to locate during the on-site survey a signed physician order for Lantus with a time specified.
It posed a significant safety concern that unlicensed staff changed the time of administration of a long acting type of insulin without a physician's order. (Per reference,Nursing Drug Handbook, Lantus has an onset of 1 hour, no peak and duration of 24 hours). The resident also had orders for a rapidly acting type of insulin, Humalog (lispro) for 4:30 PM.

On 3/15/17 after a telephone call, the ADM presented electronic evidence that a staff person (author not documented) requested an order via fax on 2/8/17 to administer the Lantus insulin along with the resident's Humalog, and requested the time of Lantus be changed to 4:30 PM (from 8 PM). The MD wrote "yes" and signed the order on 2/9/17. It was noted by a RN on 2/12/17. It could not be determined how long staff had been administering the Lantus at a different time than was ordered by the physician, due to the facility's incomplete medication documentation process.
Per review, the staff's documentation of

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R168	Continued From page 10 medication administration, initialed by staff under the time(s) stated for each date, it said only "insulin"; it did not identify the 2 types of insulin given, nor the doses ordered. Policies and procedures requested and documentation of training records to show evidence of specific training for administration of insulin by unlicensed staff was not found, per the RN on duty on 3/13/17. Refer also to R 126.	R168		
R169 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.e Staff responsible for assisting residents with medications must receive training in the following areas before assisting with any medications from the licensed nurse: (1) The basis for determining "assistance" versus "administration". (2) The resident's right to direct the resident's own care, including the right to refuse medications. (3) Proper techniques for assisting with medications, including hand washing and checking the medication for the right resident, medication, dose, time, route. (4) Signs, symptoms and likely side effects to be aware of for any medication a resident receives. (5) The home's policies and procedures for assistance with medications. This REQUIREMENT is not met as evidenced	R169	Reference POC from R126	

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R169	Continued From page 11 by: Based on staff interview and record review, there was no written evidence of the completion of the specific training required for unlicensed staff administration of medications to residents of the home. This has the potential to affect all residents of the home. Findings include: Per interview with the Registered Nurse (RN) on duty on 3/13/17 and interview with the Administrator (ADM), there was no evidence of a formal training process provided to unlicensed staff who regularly administer medications to residents of the home. There had been a frequent turn over in the position of RN of record for the facility since June, 2016 and the ADM confirmed that there were no records of the training provided available for review by the survey agency.	R169		
R171 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication,	R171	Reference RNAO #7	

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R171	Continued From page 12 and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide evidence of written procedures for monitoring of psychoactive medications. The facility also failed to provide a record of monitoring for side effects of antipsychotic medications for 2 of 6 applicable residents (Residents #1 and #4). Findings include: During record review and staff interview on 3/13/17, neither the Registered Nurse nor the Administrator could provide evidence of written procedures for monitoring side effects of psychoactive medications. This screening could be done by the RN or a copy obtained from a consultant source such as a mental health provider. Two of 5 residents in the sample (#1 and #4) lacked evidence of a periodic screening for involuntary movements known to be associated with antipsychotic medications administered to them.	R171		
R176 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management	R176		

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SCENIC VIEW RURAL EDGE LLC	979 VT ROUTE 100 WESTFIELD, VT 05874

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R176	Continued From page 13 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to promptly dispose of medications left after the death or discharge of a resident, or outdated medications. Findings include: During observation of the nurses' station on 3/13/17, the surveyor identified bubble pack cards of medication stacked on a shelf in a closet. After comparing the names on the cards with the current resident roster and the Medication Administration Record (MAR), it was determined that medications for residents who no longer reside at the facility remained stored in this closet. Additionally, there were discontinued medications for current residents also present in the closet. The Administrator and Registered Nurse on duty failed to provide a written policy and procedure for disposing of outdated or unused medication, including designation of a person or persons with responsibility for the disposal.	R176	Refer to R 160	
R178 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of	R178	NOTE: On the date of the Survey Census was 17	

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R178	Continued From page 14 qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and record reviews, the facility failed to assure that there were sufficient numbers of trained staff on duty at all hours of the day and night to maintain a safe environment. The finding has the potential to affect all residents of the home. Findings include: Per staff interviews and record review, there was evidence of insufficient staff on duty during all times of the day to monitor all residents of the home to assure a safe environment for all. An anonymous report to the licensing agency alleging possible non-consensual sexual activity between 2 residents of the home prompted an investigation of the report. 1. During record review on 3/13/17, a staff member wrote for the 3 PM to 11 PM shift on 2/27/17 that Resident #3 told a caregiver that Resident #4 had tried to show a private part to Resident #3. The caregiver wrote of reporting the allegation to another staff person [identified during interview with the Administrator (ADM) as a department manager in the home]. On 3/13/17 at 4:15 PM, the staff person named as receiving the report from the caregiver confirmed that they had been informed of the resident to resident allegation of abuse. Neither the manager nor the caregiver reported the allegation to Adult Protective Services, as required by Vermont Statute; nor did they report to the Licensing Agency. The allegation was not reported to the ADM [who was on vacation at the time]. The	R178	resident, current census of 14 Action: Staff will be added to adequately cover needs of the residents. (or same)	

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R178	Continued From page 15 allegation was also not reported to the home's ownership CEO, nor the Office Manager, nor the Registered Nurse (RN) of record, who were all identified by the ADM as part of a team of 4 staff left in charge during his/her absence from the facility for the period of 2/22/17 - 3/5/17. There was no policy /procedure for Abuse Reporting per the ADM. 2. Regarding the staffing pattern in the home; one caregiver/medication technician (1 person) was assigned to each of 3 shifts per day. During the day and early evening hours (until about 7 PM when the cook completes their duties) there are an average of 3-6 other staff in the building. After 7 PM, per interview with a caregiver who has worked the evening and night shifts on occasion, the duties required include assisting residents with their personal hygiene, providing evening snacks and assisting those who require assistance with getting into bed. The capacity of the home is 23 residents, with the census on the day of the survey listed as 17. The physical layout of the building is a long unit along a corridor downstairs, with another resident room on the second floor of the home. If there was a resident wandering into other residents' rooms for any reason, it would be difficult for 1 staff member to monitor all of these areas to assure that all residents are safe in their rooms during the evening/overnight hours.	R178		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and	R179	April 12, 2017 Action: All care staff will be required to complete 12 hrs	

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R179	Continued From page 16 techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments; blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that new staff demonstrated competency in the skills required prior to providing direct care to residents, including training in the 7 mandated trainings included in the Residential Care Home Licensing Regulations, including mandatory reports of abuse. This failure has the potential to affect all residents of the home. Findings include: Per interview with the Administrator (ADM) on 3/13/17, the home had not been assuring the competency of staff by providing necessary training to assure that each staff member was	R179	Staff training annually to be provided by RN and administrator Measure: At the end of each calendar year hours of inservice will be tracked and staff not yet with 12 hrs will be tasked with completion Monitored: Adm/RN will track annual education hrs to insure staff have met requirements	

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R179	Continued From page 17 competent and proficient in using the skills needed to provide care for each resident of the home. During the survey, it was discovered that a resident of the home alleged abuse by another resident to a staff member. During interview, the ADM confirmed that they had not previously been made aware of this allegation. The staff member who received the allegation stated during interview with the surveyor that they discussed the allegation with the another staff member and they decided that it was not a credible allegation and thus, it was never reported to administration, Adult Protective Services (APS) or the Licensing Agency per Vermont Statute. During interview regarding training education at the home, the same staff member confirmed that they had worked at the facility for 3 years and had never received training on abuse reporting and facility Abuse Protocols. Refer also to R 208 and R 181.	R179		
R181 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement,	R181	Action: Paperwork filed with Rabbit DAIC Registry for automated checks. One paperwork granted all staff, to include new hires, checks will be complete	Apr. 1 12, 2017

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R181	Continued From page 18 including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record reviews, the facility failed to complete the required background checks for new hires to include the Vermont Adult Abuse and Child Abuse Registries for 3 of 3 staff in the sample. This finding has the potential to affect all residents of the home. Findings include: Per review of a sample of 3 staff personnel records, there was no evidence of background checks of the Vermont Adult and Child Abuse Registries for the 3 staff. During interview, the Administrator (ADM) stated that the only agency checks being completed for new hires at the present time included the Vermont Criminal records checks; S/he was not aware of the requirement to conduct the Abuse Registry checks for new employees. The failure to check the Adult and Child Abuse Registries for new employees of the home puts residents at risk of potential abuse by a person found guilty of abusing a person meeting the definition of a vulnerable person, per Vermont Statutes. Refer also to R 208.	R181	Measures: Once registered check on current and new hires would be complete and results placed in personel file. Monitord: Check new hires	
R200 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures	R200	Action 1. P&P update for proper dating of food as well as temperature	May 1. 2017

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R200	Continued From page 19 Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide evidence of written policies and procedures to govern all of the services provided by the home. This has the potential to affect all residents. Findings include: Per interviews with staff from the Dietary Dept, Nursing Dept, and the Administrator (ADM) throughout the day on 3/13/17, the facility failed to have Policies/Procedures to address the following identified areas. 1. Per interview with the Dietary Manager during a discussion regarding the lack of daily documentation for refrigerator and freezer temperatures, the manager confirmed that s/he was not aware of any policy/procedure (P/P) to address this process. S/he stated that staff were assigned to record the temperature of each refrigerator and freezer everyday to show evidence of monitoring to assure perishable foods were stored at safe temperatures to prevent growth of harmful bacteria. The Dietary Manager also confirmed that there was no P/P to direct staff in the process of proper dating foods to assure that all food stored is safe palatable. 2. Per interview with the ADM regarding a staff member's record entry regarding an alleged resident to resident incident of abuse, s/he confirmed that there was no P/P to address the facility's procedure for Mandatory Abuse Reporting. The ADM confirmed that they had not	R200	recordings of any corrective measures: 1. P&P online how to record temperatures daily P&P on labeling food Monitored 1. Temperature recorded daily on flow chart and initialed by staff Action for 2 #1 P&P established for documentation of incident Measure: #1 Staff educated on appropriate reporting of abuse/incident, when reporting takes place and whom to notify	

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R200	Continued From page 20 been made aware of the allegation of abuse, nor had staff reported the alleged abuse to the ADM's designee while they were away from the facility for several days. The ADM also confirmed that they had no P/P to address how staff should document and report any incidents, events or occurrences related to resident injury and falls, unusual events, and potentially harmful events or possible resident abuse. There were no incident/event report forms to direct staff in completion of the reports and who must be notified. Refer also to R 181,R 232, R 247 and R 208.	R200	Monitored: Compile incident reports will be kept on file and followed up with appropriately	
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to report to the licensing agency an allegation of sexual abuse by one resident (#4) toward another resident (#3) on 2/27/17 (2 of 6 residents sampled). Findings include:	R208	Action: 1. P&P established for abuse reporting 2. Protocol for abuse training for new hires established Measures: 1. P&P reviewed with staff and training provided to new hires Monitored: Abuse reporting	May 12, 2017

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R208	Continued From page 21 1. During record review on 3/13/17, a staff note for the 3 PM to 11 PM shift on 2/27/17 mentioned that Resident #3 told a caregiver that Resident #4 had tried to show a private part to Resident #3. The caregiver wrote of reporting this to another staff person (named). On 3/13/17 at 4:15 PM, the staff person named as receiving the report from the caregiver confirmed having been told of the resident to resident allegation. Neither staff member reported the allegation to administration, the Licensing Agency, or Adult Protective Services. Additionally, neither staff interviewed had received any training in Mandatory Abuse Reporting (See R 179). During interview, the ADM confirmed that training in Abuse Reporting is not being done for new hires prior to working with the residents of the home. Refer also to R 200.	R208	will have accompanying paperwork securely filed.	
R232 SS=B	VII. NUTRITION AND FOOD SERVICES 7.1.a.(1) Menus for regular and therapeutic diets shall be planned and written at least one (1) week in advance. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the full menu for the week at least one week in advance, as required. Findings include: Per observation on 3/13/17, the menu that was posted in the kitchen and the dining room failed to include all of the items being served at each meal; for some meals only the entree item was	R232	April 13.2017 Action: Current wk menu and one wk in advance will be posted Measure: Posting of current and forthcoming wk menus @ all times Monitor Previous & future menus will be kept on file	

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R232	Continued From page 22 included. Additionally, the menu for the current week, for Saturday, was incomplete and had no entree listed. This observation was confirmed during interview with the Dietary Manager.	R232		
R236 SS=B	VII. NUTRITION AND FOOD SERVICES 7.1.a. (5) The home shall keep menus, including any substitutions, for the previous month on file and available for examination by the licensing agency. This REQUIREMENT is not met as evidenced by: Based on staff interview, the home failed to assure that there was a system for keeping menus for the previous month on file and available for review by the licensing agency. Findings include: Per interview with the Dietary Manager, who was newly hired at the facility, there were no menus available for the previous month as required. A system to assure that this practice was carried out was not in place at the time of the survey.	R236	Refer to R232	
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced	R247	Refer to R202	

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R247	Continued From page 23 by: Based on observation and record review, the dietary staff failed to show evidence of monitoring refrigerator and freezer temperatures to assure that they were maintaining temperatures within the safe ranges. Additionally, there was no policy/procedure to address the dating procedures to be used for storage of perishable foods in the refrigerator or freezer. All residents are potentially affected. Findings include: Per observation of the refrigerator and freezer temperatures in the kitchen and food storage room on 3/13/17, there were many days and times when staff failed to document refrigerator and freezer temperatures daily; per interview, the Dietary Manager confirmed the incomplete documentation at the time of the observations. For the log located in the kitchen, for the period from 1/17/17 - 3/12/17, there were 15 days when staff failed to document the daily temperatures on the log. The log used in the food storage room was also incompletely documented with the daily temperatures. During an observation of the refrigerator in the kitchen, 3 packages of ground beef were seen thawing in the refrigerator. When asked what day the beef was removed to the refrigerator to be thawed, the Dietary Manager was not sure; the dates on the package indicated the date when the packages were first frozen. It is necessary to assure food are used within the times specified in a facility's food dating policies and procedures, to assure that foods are still fresh and safe to consume. The Dietary Manager was not aware of any P/P to address the facility's dating of perishable foods. Refer also to R 200.	R247		

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R266 SS=B	IX. PHYSICAL PLANT	R266		

9.1 Environment

9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to assure that all resident areas of the home were sanitary and homelike regarding 2 applicable areas that may be utilized by any resident of the home. This finding has the potential to affect all residents of the home. Findings include:

Per observations of the living room area of the home, 2 sofas and an upholstered chair were observed with many soiled and/or stained areas on each one. The stains were brownish, with large streaks and dotted areas. When the Administrator (ADM) was asked about the routine cleaning of furniture and whether or not upholstery cleaning had been done, s/he replied that s/he was not aware of whether or not staff had cleaned the upholstered furniture in the living room.
The bathroom off of the living room area had a sign on the door stating it was for use by visitors/staff; it was also used to give showers to some residents, per staff and resident interviews. A large area of the flooring in the bathroom was noted to be very discolored around the toilet. The bathroom also had unlocked cleaning compounds stored on the floor, a toilet bowl brush cleaner, a plunger and the floor mop and bucket used for

Action
1. Estimate for furniture cleaning obtained
2. Older furniture will be discarded when weather permits
3. Estimate pending for bathroom tile replacement.
4. Cleaning compounds have been removed

measure
Staff education on proper cleaning and storage

Monitored:
Quarterly checks for furniture cleaning or disposal.

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R266	Continued From page 25 cleaning stored in the room; the bathroom was not homelike nor attractive for use as a resident bathroom.	R266		
R999 SS=F	MISCELLANEOUS Scope/Severity: F 4.13c. The manager shall not leave the premises without delegating necessary authority to a competent staff person who is at least eighteen (18) years of age. Staff left in charge shall be qualified by experience to carry out the day to day responsibilities of the manager, including being sufficiently familiar with the needs of the residents to ensure that their care and personal needs are met in a safe environment. Staff left in charge shall be fully authorized to take the necessary action to meet those needs or shall be able to contact the manager immediately if necessary. Based on staff interviews and record review, the Manager/Administrator (ADM) of the home went on vacation for a period of 12 days and failed to leave qualified staff in charge to ensure that the care and personal needs of the residents were met in a safe environment. Findings include: Per investigation and reviews of allegations made in a complaint to the licensing agency, it was determined that the ADM failed to assure that staff who were left in charge during their absence from the facility were qualified by experience and knowledgeable of residents' needs to assure all needs were met in a safe environment. During interview regarding who was designated to be in charge of the home while away, the ADM stated that s/he designated 4 staff to be in charge in their absence. The 4 staff included a Registered Nurse (RN), the Dietary Manager, the Office	R999	Action: 1. Office Mgr registered (RN) VHCA managers advise 2. Education provided on new & updated P&P Measure Continued education of all staff current and new Monitored. Monitored by Adm.	April 2017

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC VIEW RURAL EDGE LLC	979 VT ROUTE 100 WESTFIELD, VT 05874

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R999	Continued From page 26 Manager and the CEO of the ownership company. Of the 4 staff, the CEO stated that they had no previous experience with running a residential health care facility and confirmed that they had taken ownership in June, 2016. For the remaining 3 staff left in charge, none of the 3 were sufficiently knowledgeable regarding regulatory requirements for Licensed Residential Care Homes. They were all recently hired and they had not yet completed mandated training for employees of the home, including Mandatory Abuse Reporting per Vermont Statue. During the ADM's absence from the home, a resident allegation of abuse by another resident was reported to a staff member who notified one ADM/designee who, due to a lack of knowledge regarding Mandatory Abuse Reporting, failed to report the allegation to APS (Adult Protective Services). One former staff member left in charge at this time confirmed that they did not feel qualified by experience to fulfill that role.	R999		